Psychology, Public Policy, and Law
2003, Vol. 9, No. 1/2, 70–93

Copyright 2003 by the American Psychological Association, Inc.
1076-8971/03/$12.00 DOI: 10.1037/1076-8971.9.1-2.70

ENDORSEMENT OF PERSONAL BENEFIT OF OUTPATIENT COMMITMENT AMONG PERSONS WITH SEVERE MENTAL ILLNESS

Marvin S. Swartz and
Jeffrey W. Swanson
Duke University Medical Center

John Monahan
University of Virginia

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

This study examines whether individuals who experienced involuntary outpatient commitment (OPC) attribute benefit to this intervention. It was found that the majority of experimental subjects who underwent a period of OPC did not personally endorse OPC's benefits at the end of the study, either because they did not think it improved treatment adherence or because they rejected their own need for continued treatment. However, at the end of the study, a positive appraisal of benefit was roughly twice as likely among subjects who actually experienced positive treatment outcomes. These data provide little support for acceptance and "gratitude" as a rationale to support decision making about OPC continuation. Rather, clinicians need to rely on other clinical and empirical data for such decision making.

The use of involuntary outpatient commitment (OPC) to reduce high rates of relapse and related negative outcomes among persons with severe mental illness (SMI) has gained increasing attention from mental health policy makers and clinicians (Allen & Smith, 2001; Appelbaum, 2001; Gerbasi, Bonnie, & Binder, 2000; Kress, 2000; Lamb & Weinberger, 2000; Mattison, 2000; Mulvey, Geller, & Roth, 1987; Steadman et al., 2001; Stein & Diamond, 2000; Swartz & Monahan, 2001; Torrey & Zdanowicz, 2001). Court-mandated community treatment, a less restrictive alternative to hospitalization, is intended to facilitate patients' adherence with medication and psychosocial interventions and thereby improve a range of treatment outcomes. However, critics of OPC claim that its potential therapeutic benefits are seriously undermined by its coercive effects (Allen & Smith, 2001). This article brings new evidence to bear on questions regarding the effectiveness of OPC, which is relevant to its ethical status, by

Marvin S. Swartz and Jeffrey W. Swanson, Department of Psychiatry & Behavioral Sciences, Duke University Medical Center; John Monahan, School of Law, University of Virginia.

This research was supported by two grants from the National Institute of Mental Health: Effectiveness of Involuntary Outpatient Commitment (R01-MH48103-05) and Program on Services Research for People with Severe Mental Disorders (P50-MH51410-02). Additional support was provided by the MacArthur Foundation Initiative on Mandated Community Treatment. We gratefully acknowledge the contributions of Virginia A. Hiday, H. Ryan Wagner, and Barbara J. Burns, who participated in the study and helped develop these analyses. We also acknowledge the support and cooperation of many state mental health personnel, judges, clinicians, administrative staff, and law officers from Durham, Vance, Franklin, Granville, Warren, Orange, Person, Chatham, and Guilford counties in North Carolina who participated in this study. We acknowledge the helpful comments and suggestions of Professors Bruce Winick and Ken Kress.

Correspondence concerning this article should be addressed to Marvin S. Swartz, Professor of Psychiatry & Behavioral Sciences, Duke University Medical Center, Box 3173, Room 238 Civitan Building, Durham, North Carolina 27710. E-mail: swart001@mc.duke.edu

examining whether individuals who have been subjected to OPC attribute personal benefit to this legal intervention in hindsight. We measure the extent to which an endorsement of benefit associated with OPC is conditioned on individuals experiencing tangibly positive treatment outcomes, such as avoiding hospitalization and violent behavior, and achieving improved independent functioning in the community.

Research Base on Involuntary Outpatient Commitment

Empirical evidence regarding OPC's effects has accumulated in the past several decades. Studies conducted in the 1980s reported a number of positive outcomes under OPC, including decreased hospital readmission rates, diminished lengths of stay, and increased access to community-based services (Fernandez & Nygard, 1990; Hiday, 1992; Hiday & Scheid-Cook, 1987; Hiday & Scheid-Cook, 1989; Hiday & Scheid-Cook, 1991; Keilitz, 1990; Moloy, 1992; Swanson et al., 1997; Swartz et al., 1995). Later research into OPC in the 1990s included two randomized controlled trials (RCTs) in North Carolina and New York City (Steadman et al., 2001; Swanson et al., 2000; Swanson et al., 2001; Swartz et al., 1999; Swartz, Swanson, Hiday, et al., 2001).

The North Carolina study found that sustained OPC was effective in improving treatment outcomes (Swanson et al., 2000, 2001; Swartz et al., 1999, 2001). Specifically, subjects who underwent sustained periods of OPC, while concurrently receiving frequent outpatient services, experienced significantly improved treatment adherence and reduced hospital admissions with fewer days hospitalized, were less likely to be violent, and were less likely to be criminally victimized when compared to subjects who received an equal or greater number of service encounters without OPC or with only a brief, nonrenewed period of court-ordered treatment. Sustained OPC was shown to be particularly effective in reducing hospital recidivism for individuals with psychotic disorders. In a subgroup of subjects with a combined history of multiple hospitalizations and prior arrests/violence, sustained OPC was also associated with a significant reduction in the likelihood of re-arrest during the study year.

The other randomized study of OPC, conducted in New York City, evaluated a pilot OPC program at Bellevue Hospital (Steadman et al., 2001). Subjects in the study were randomly assigned to court-ordered OPC or release, but all received enhanced treatment services. Although the evaluation found that subjects benefited from enhanced services, there was insufficient evidence that the court order per se was beneficial. Steadman and colleagues report that under this newly initiated statute, enforcement was not fully operational, which limits the interpretability of this experiment.

Despite some of these positive findings regarding the effectiveness of OPC, many mental health consumers and mental health law advocates strongly oppose court-ordered mental health treatment; they argue that coerced outpatient treatment infringes on civil liberties, undermines the dignity of persons with mental illness, damages therapeutic relationships, and drives people away from needed services and treatment (Allen & Smith, 2001; Campbell & Schraiber, 1989; Schwartz & Costanzo, 1987; Stefan, 1987). Despite these claims, there has been

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

little empirical work on how clients who receive OPC evaluate its benefits or limitations.

In the current study, we pose several empirical questions: (a) Do subjects who have been subjected to OPC retrospectively perceive OPC to be beneficial in improving treatment adherence, while simultaneously acknowledging their need for treatment? (b) Do some subjects' negative perceptions of OPC as unduly coercive affect their appraisal of OPC's benefits? (c) Is the endorsement of the personal benefits of OPC conditioned on positive treatment outcomes experienced under OPC? This study begins to address these questions by examining personal beliefs in the benefits of OPC among subjects in the North Carolina experimental trial.

Patient Perceptions of Coerced Treatment

Clinicians have long noted that some individuals with severe mental illness who initially require involuntary treatment will later, presumably when they are recovered, come to view the treatment as needed and, in retrospect, will even feel grateful for having received forced intervention at a time when they could not recognize or make a reliable decision about their need for treatment. Some scholars have viewed such personal reappraisals of the need for involuntary treatment as an ethical justification for the policy and practice of court-mandated treatment. Stone (1975) termed this rationale for involuntary commitment the *thank-you theory*. In effect, the retrospective acknowledgement of need for involuntary treatment attenuates or weakens the strong paternalism of imposed treatment. Several investigators have sought to empirically evaluate whether patients actually revise their views regarding their need for involuntary treatment on the basis of their own experience and later attribute benefit to such intervention.

Kane and co-workers (Kane et al., 1983) queried involuntarily hospitalized patients about their need for involuntary commitment. They found that patients were more likely to endorse a need for commitment when they were questioned near the time of hospital discharge compared to the time of admission. Kane and colleagues acknowledge that they selected for interview patients who strongly objected to commitment; hence, a change in these patients' attitudes might have represented a normative softening of opposition to commitment, that is, a "regression to the mean." Alternatively, these patients may have believed that their acquiescence to their psychiatrist's view that they had needed treatment was socially desirable and might confer an advantage by hastening discharge.

Edelsohn and Hiday (1990) interviewed a group of patients who had been involuntarily hospitalized 6 months after discharge. In retrospect, a majority (54%) of these patients believed that they should have been hospitalized, whereas an even greater proportion (57.8%) viewed involuntary hospitalization as necessary; however, somewhat paradoxically, only a minority (25.1%) believed that they had met commitment criteria at the time. The majority (61%) wished to be involuntarily committed in the future in the event that they become seriously ill to the point of being dangerous.

Adams and Hafner (1991) examined attitudes toward guardianship and involuntary treatment in South Australia. Although 70% of patients under guard-

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

ianship stated they should not be under guardianship, nearly 50% described it as helpful; nearly 60% also rated involuntary treatment as helpful. The authors note that even though the majority of patients objected to enforced treatment, most found the actual experience beneficial. Similarly, a study by Schwartz and co-workers (Schwartz, Vingiano, & Perez, 1988) found that of 24 patients who were involuntarily medicated, only 7 at discharge disagreed with the decision to medicate them forcibly. Lucksted and Coursey (1995) examined perceptions of pressure and force in psychiatric treatment in a group of severely mentally ill outpatients. While examining a broad range of coercive efforts that were brought to bear on these patients, they found that 57% of respondents reported some coercion in hospitalization, and 30% reported coercive pressure in medication adherence. A large majority supported the use of force in some situation, and 30% said pressure or force was always appropriate if it was in the client's best interest.

Gardner and co-workers (Gardner et al., 1999) examined whether hospitalized psychiatric patients revised their beliefs about the need for hospitalization. After discharge from the hospital, 52% of patients who had indicated on admission that they did not need hospitalizations, in retrospect, believed they had needed it. However, of those involuntarily admitted, 61% continued to believe they did not need hospitalization. By inference, voluntarily admitted patients are more likely to acknowledge, upon discharge, that they needed hospitalization. The revision in beliefs was unrelated to perceptions of coercion; committed patients' perception of coercion was unchanged even when they believed the hospitalization was necessary. Gardner et al. suggest that a revised view of the need for hospitalization may be unrelated to perceived coercion, and patients who acknowledged the benefit of involuntary treatment may not have been grateful for the experience, contrary to the premises of the thank-you theory. Even though these studies shed some light on perceptions of involuntary treatment in the hospital setting, none bear direct relevance to the perceived benefits of OPC.

A study that used baseline data from the North Carolina experimental trial of OPC examined beliefs and perceptions of OPC among patients who had received a court order to be discharged under OPC after involuntary admission. Three quarters of these patients believed that OPC would help individuals in general—though not necessarily themselves—take medication as prescribed, keep mental health appointments, and stay out of the hospital (Borum et al., 1999).

In the current study, we examine subjects' beliefs about the personal benefits of OPC after their experience of court-ordered treatment. These patients were questioned at the end of a randomized controlled trial of OPC in North Carolina (Swanson et al., 2000, 2001; Swartz et al., 1999; Swartz, Swanson, Wagner, et al., 2001). We hypothesized that subjects would be more likely to perceive OPC as personally beneficial at the end of this 12-month trial if they had experienced tangible positive treatment outcomes under OPC, such as remaining out of the hospital, avoiding violent behavior, and achieving a relatively high degree of independent functioning in the community. We report descriptive analyses of beliefs regarding the personal benefits of OPC, as well as multivariate logistic regression analyses of the effects of sociodemographic and other predictors on these beliefs.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

Study Design and Sample

Selection Criteria

Subjects were screened sequentially from a population of involuntarily hospitalized patients who had been ordered to undergo a period of OPC upon discharge. Eligibility criteria for the study were (a) age 18 years or older; (b) diagnosis of schizophrenia, schizoaffective disorder, other psychotic disorder, or major affective disorder; (c) duration of disorder of 1 year or more; (d) significant functional impairment in activities of daily living; (e) intensive treatment within the preceding 2 years; (f) resident of one of nine counties participating in the study; and (g) awaiting a period of court-ordered outpatient commitment. In North Carolina, involuntary outpatient commitment criteria include the presence of serious mental illness; the capacity to survive in the community with available supports; a clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerous behavior; and a mental status that limits or negates the individual's ability to make informed decisions to seek or to comply voluntarily with recommended treatment (Swartz et al., 1999).

Study Group Assignment

By special arrangement with the court, subjects who were randomly assigned to a control group were released from OPC. Subjects in the experimental group, by law, received an initial period of OPC not longer than 90 days. Thereafter, the commitment order could be renewed for up to 180 days if a psychiatrist and the court determined that the subject continued to meet legal criteria for OPC. However, subjects in the control group received immunity from any OPC during the year of the study. All subjects received case management and other outpatient treatment at one of four participating area mental health programs that represent nine contiguous urban and rural counties. An exception to the randomization procedure was necessary in the case of patients with a history of serious assault involving weapon use or physical injury to another person within the preceding year. These subjects (the seriously violent group) were required to undergo at least the initial period of OPC as ordered. Renewals were left to the discretion of the clinician and court.

Refusal, Attrition, and Differences in Length of Time on OPC

Of identified eligible patients, 12% refused consent to participate. Rates of refusal did not significantly vary by sex, race, or diagnosis. Patients over age 45 were more likely to refuse than those under 45 (14% vs. 7%). The baseline sample consisted of 331 subjects. At the 12-month follow-up, 73 subjects (20.9%) had withdrawn, were lost to follow-up, or had missing data. A total of 258 subjects remained for longitudinal analysis: 113 in the control group, 100 in the OPC group, and 45 in the OPC violent group. Attrition did not differ significantly by group. There was no evidence of sample bias in renewal of OPC orders, except that patients with a baseline history of medication noncompliance were somewhat more likely to receive extended OPC (40.0% vs. 18.75%). (The potential implications of this difference for interpretation of the results will be discussed later.)

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

Approximately one third of subjects in both the OPC and violent-OPC groups received more than 180 days of court-ordered treatment.

Because the present paper deals with the attitudes of persons subjected to OPC, and the question of whether the outcomes that they experience under OPC may shape those attitudes, it is only the experimental subjects (i.e., those who received OPC) who are of direct interest for these analyses. For this purpose, all of the subjects who were assigned to OPC and were retained during the study year (the randomized sample [$n = 100$] and those with a history of serious violence [$n = 45$]) are combined into one group ($n = 145$). Of these, 22 individuals had missing data on either the dependent variable or a key independent variable in these analyses, which left a final subsample of 123 subjects.

Data Collection

At baseline, structured interviews were conducted with each subject and with a family member or other informant who knew the respondent well. Hospital records were reviewed for additional information regarding clinical history. Follow-up interviews were conducted every 4 months with the subject, case manager, and collateral informant. Outpatient service records and hospital admissions were recorded as well.

Measurement

Dependent variable: belief in the personal benefit of outpatient commitment. A composite attitudinal typology was constructed from two dimensions: (a) whether the subject generally endorsed the belief that OPC helps people adhere to prescribed psychiatric treatment, and (b) whether the subject acknowledged a personal need for continuing treatment in the future. We measured the second dimension by using items from the Insight and Treatment Attitudes Questionnaire (ITAQ; McEvoy et al., 1989). In both dimensions, *treatment* was specified to include prescribed medications and scheduled appointments with a mental health service provider.

The juxtaposition of the two dimensions yielded four possible types of attitudinal responses to OPC:

1. General endorsement OPC, but without acknowledgment of personal need for treatment;
2. General endorsement of OPC with acknowledgment of personal need for treatment;
3. Acknowledgment of personal need for treatment, but without endorsement of OPC;
4. No endorsement of OPC and no acknowledgment of need for treatment.

Figure 1 depicts these four types of responses and the prevalence of each type in the sample that was subjected to OPC. Responses were measured 12 months after baseline hospital discharge (i.e., 1 year after subjects began court-ordered outpatient treatment). Those respondents with attitudes of Type 2 ($n = 34$; 27.6%) were defined operationally as the group who "believed OPC to be personally beneficial." The other three types of responses were grouped together as a comparison group, comprised of those who "did not believe OPC to be personally

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

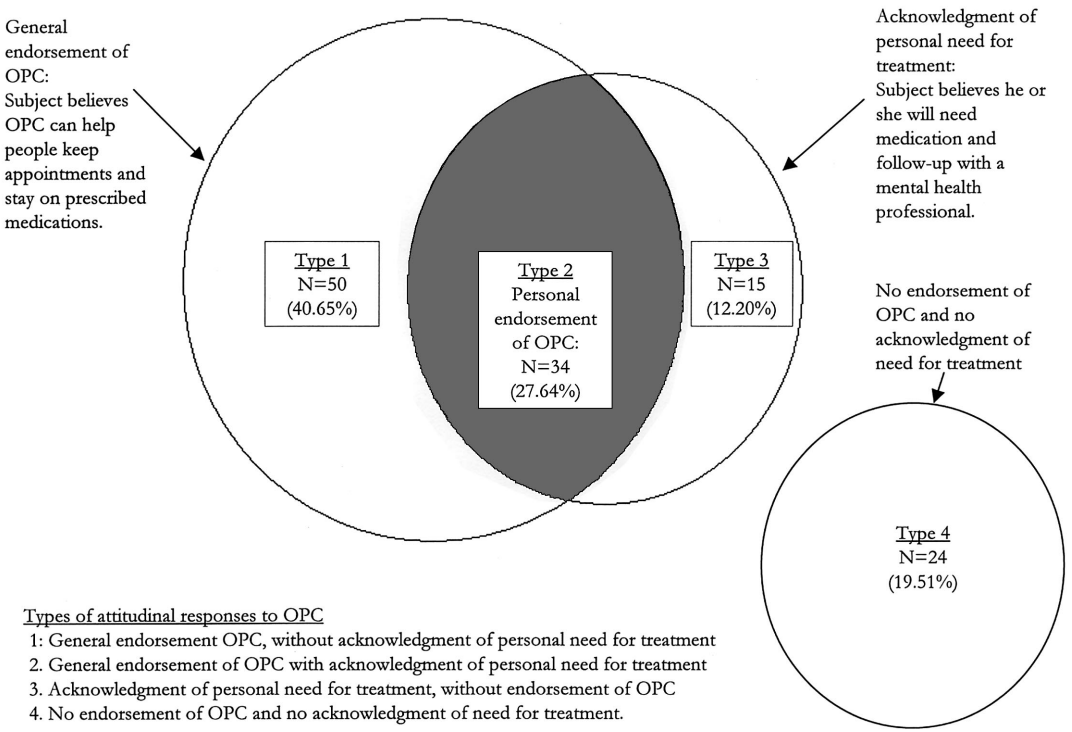

General endorsement of OPC: Subject believes OPC can help people keep appointments and stay on prescribed medications.
Acknowledgment of personal need for treatment: Subject believes he or she will need medication and follow-up with a mental health professional.
Type 1 N=50 (40.65%)
Type 2 Personal endorsement of OPC: N=34 (27.64%)
Type 3 N=15 (12.20%)
No endorsement of OPC and no acknowledgment of need for treatment
Type 4 N=24 (19.51%)
Types of attitudinal responses to OPC
1: General endorsement OPC, without acknowledgment of personal need for treatment
2. General endorsement of OPC with acknowledgment of personal need for treatment
3. Acknowledgment of personal need for treatment, without endorsement of OPC
4. No endorsement of OPC and no acknowledgment of need for treatment.

Figure 1. Prevalence of attitudinal responses to involuntary outpatient commitment after 12 months.

beneficial," because they did not believe that OPC helped improve treatment adherence, or because they did not acknowledge their own need for treatment, or both.

Independent variable: mental health outcomes. To answer the central question of whether subjects on OPC would be more likely to endorse this legal intervention as personally beneficial if they experience tangibly positive mental health outcomes, we constructed a broad-based composite measure of a "good outcome." The measure included three criteria: (a) having no psychiatric hospital admissions during the study year, (b) having no episodes of violent behavior (as measured by self-report, clinician report, family report, or official record) during the study year, and (c) achieving a Global Assessment of Functioning (GAF) score above the group median across follow-up waves. OPC patients who met all three criteria ($n = 38$; 30.9%) were coded as having a positive outcome; those who failed to meet one or more of the three criteria ($n = 89$; 65.1%) were coded as having a negative outcome.

Baseline predictors examined as potential covariates. Sociodemographic variables that were examined as potential predictors of attitudes regarding OPC included age, gender, race, marital status, education, income, social support, and history of homelessness. We assessed social support by using a subscale of the Duke Social Support Scale (George, Blazer, & Hughes, 1989) that measured respondents' subjective perception of their status and value in a social network, of whether the network would provide help if needed, and of their satisfaction with the quantity and quality of received support. Homelessness was measured by self-report and was coded positive if the respondent indicated that he or she had no regular residence before admission to the hospital or had spent time sleeping outside without shelter, inside an empty building, or in a public shelter at any time during the 4 months preceding admission.

Clinical variables that were examined included psychiatric diagnosis, functional impairment, symptoms, substance abuse, prior psychiatric hospitalizations, violence, and history of nonadherence with medication. Hospital chart diagnoses were used to code patients into major categories of psychotic versus mood disorder. A subsample of patients (155 out of the original 331) were administered the Structured Clinical Interview for DSM–IV (SCID) (First, Spitzer, Gibbon, & Williams, 1996) as a validation study; acceptable agreement was found between chart diagnoses and SCID diagnoses ($\kappa = 0.72$). To assess functional impairment, we used the Global Assessment of Functioning Scale (GAF), a measure of functional status and severity of psychiatric disturbance rated on a continuum of 0–100 from most to least impaired (Endicott, Spitzer, Fleiss, & Cohen, 1976). We used the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) to assess psychiatric symptoms. The BSI score was used in these analyses. Baseline medication adherence was measured by an index that combined self-report and family/collateral report; subjects were coded nonadherent if they were prescribed psychotropic medications during the 4 months preceding hospitalization, but reportedly never (0%–25% of the time) took the medications or only sometimes (26%–49% of the time) took them as prescribed (Swartz et al., 1998).

We assessed substance abuse at baseline by combining interview data from three sources: medical record review, subject interview, and family/collateral interview. Substance abuse was defined operationally as any reported occurrence

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

of problems related to alcohol or illicit drug use—problems with family, friends, job, police, physical health—and/or a recorded chart diagnosis of psychoactive substance use disorder (Swartz et al., 1998). Similarly violent behavior was assessed from three data sources: Subjects were asked whether they had been picked up by police or arrested for physical assault on another person, had been in fights involving physical contact, or had threatened someone with a weapon. In addition, family members were asked comparable questions about the subject's behavior, and hospital records and civil commitment petitions were reviewed for documentation of violence. A composite index was constructed to measure whether at least one violent act was reported by any source (Swanson, Borum, Swartz, & Hiday, 1999).

Methods of Analysis

Logistic regression analysis was used to examine the relative impact of positive mental health treatment outcomes on endorsement of personal benefit of OPC. Odds ratios (ORs) produced by this technique estimate the average change in the odds of a predicted condition or attitudinal state (perceived personal benefit vs. no benefit attributed to OPC) that is associated with an independent variable of interest. For independent variables measured on a continuous scale or ranking, the OR indicates the change in event likelihood per unit change in the predictor.

Sample Description

Demographic characteristics. Subjects in the Duke Outpatient Commitment Study were predominantly young to middle-aged adults (mean age = 39 years), of lower income (median = $6,000 annually), lower educational status (38% did not complete high school), and mostly single (80% not married or cohabiting). The racial distribution of the sample was 66% African American, 33% non-Hispanic White, and 1% other race. During the 4 months preceding baseline hospital admission, 20% had been homeless. A majority (58%) were city residents, but a substantial proportion (42%) lived in rural areas and small towns. This sample was demographically representative of the population of patients admitted to state mental hospitals in North Carolina.

Clinical characteristics, substance abuse, and violence history at baseline. The majority of the sample (68%) had diagnoses of psychotic disorders (primarily schizophrenia and schizoaffective disorders); 28% had bipolar disorder, and 4% had recurrent major depression. Thirteen percent (13%) had a co-occurring diagnosis of a personality disorder. The majority of the sample had moderate-to-severe functional impairment (GAF median score = 47). Co-occurring alcohol and drug abuse (35%), medication noncompliance (73%), and violent behavior (51%) were common in the 4 months prior to hospitalization. More than one third (38%) had experienced two or more psychiatric hospital admissions during the preceding year. For a more extensive presentation of the sample, see Swartz et al. (1999) and Swanson et al. (1999).

Results

Overall, 47.9% of the OPC subjects ascribed personal benefit to OPC prior to discharge at baseline, while 27.6% ascribed personal benefit to OPC after 1 year.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

A majority of subjects at both time points did not believe OPC to be personally beneficial because they did not believe OPC was effective, or because they did not acknowledge their own need for treatment, or both.

Figure 2 shows the distribution of the combination of responses at baseline and 12 months for OPC subjects who provided attitudinal data at both time points (n = 119), that is, before and after their experience of OPC. The most frequent response pattern (41.2%) was a negative appraisal of benefit both at the start and at the end of the study. The second most frequent response pattern (30.3%) was a positive endorsement at the beginning of the study, which became a negative endorsement by the end of the study. As Figure 3 and the subsequent analyses show, these patterns of response were modified by whether the subjects experienced a tangible positive versus negative treatment outcome under OPC, that is, whether it "worked" in terms of staying out of the hospital, avoiding violence, and achieving better-than-average functioning in the community (GAF score above median).

Figure 3 shows distributions of subjects' attitudes regarding OPC from baseline to 12 months, stratified by mental health treatment outcome as defined earlier. This analysis shows that, compared to subjects with negative outcomes, subjects with positive outcomes were more than twice as likely to convert from a negative to a positive endorsement of personal benefit of OPC (18.4% vs. 7.4%). Also, among subjects who experienced a positive outcome, a much smaller proportion (23.7% vs. 49.4%) exhibited a negative/negative attitudinal pattern; they rejected OPC both at baseline and 12 months. However, it is also notable that the positive/positive attitudinal pattern was more frequent among subjects who

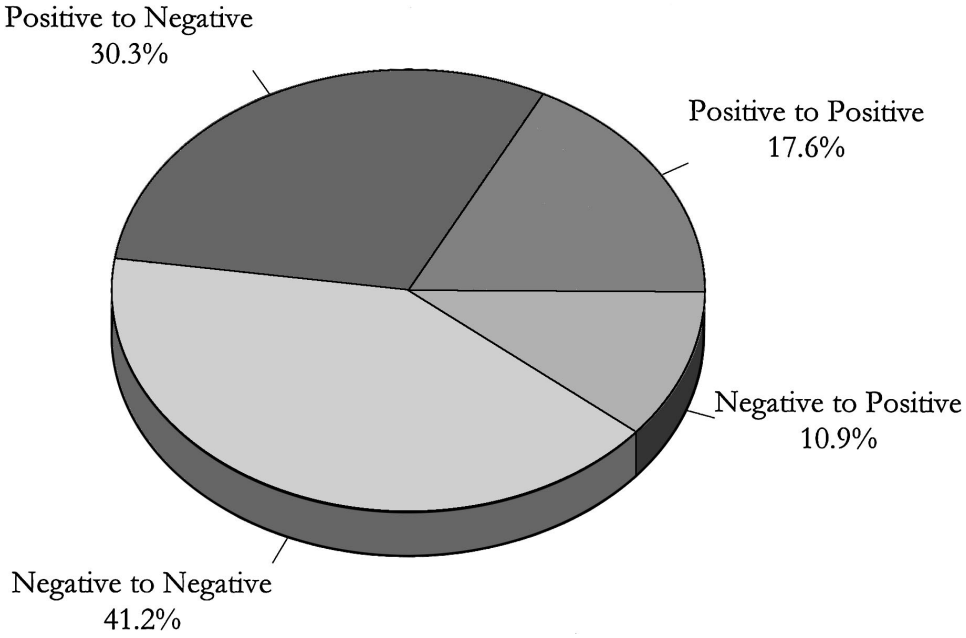


Figure 2. Change in attitude endorsement of involuntary outpatient commitment from baseline to 12 months (n = 119).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

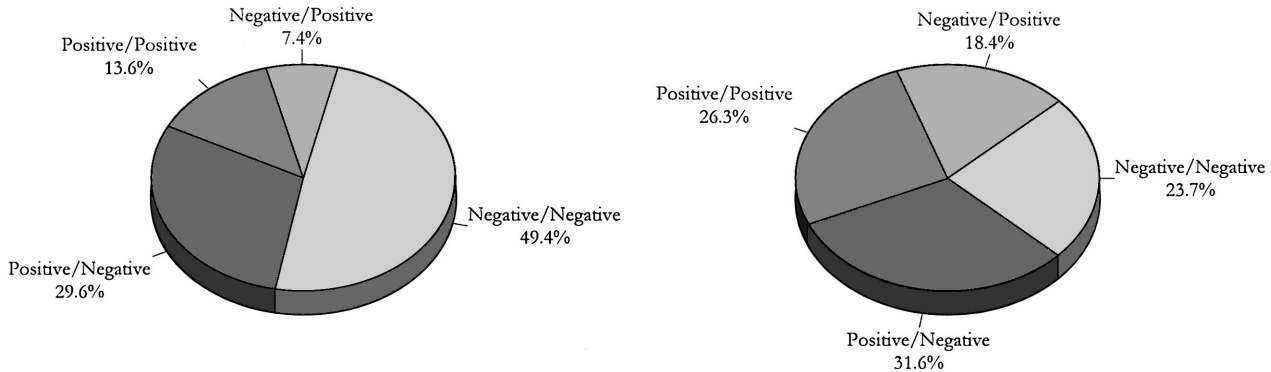


Figure 3. Change in attitude/endorsement of involuntary outpatient commitment (OPC) from baseline to 12 months by mental health outcome on OPC. GAF = Global Assessment of Functioning.

achieved a positive mental health outcome in the end, which suggests that subjects' baseline attitudinal approach to OPC might also have contributed to a better response to treatment and thus a better objective result.

Table 1 presents bivariate associations of baseline risk factors with the belief of benefits of OPC after 1 year. The likelihood of positive endorsement of benefit was significantly higher among subjects who experienced positive versus negative mental health outcomes (44.7% vs. 20.0%; Fisher's exact two-tailed test, $p < .01$) and among female compared to male subjects (40.0% vs. 17.7%; Fisher's exact two-tailed test, $p < .01$).

Figure 4 shows that this effect was confined to subjects who actually experienced OPC during the study. In the control group (i.e., those released from OPC by random assignment at baseline), subjects' mental health outcome was not associated with their endorsement of benefit of OPC. This finding suggests that the experimental group's higher endorsement of OPC, conditioned on a positive outcome, was likely attributed by them to their personal experience with OPC and was not part of some larger impact of the study on all subjects' attitudes about OPC irrespective of group assignment.

Whereas every patient who was assigned to OPC received a court order for treatment, there was natural variability in the degree of coercive pressure actually applied to these persons and in their perception of such coercion. The analysis shown in Figure 5 suggests that the association between a positive treatment outcome and endorsement of OPC was conditioned on the felt presence of coercion. Among subjects who felt little coercion (i.e., those scoring below the median on the modified MacArthur Admissions Experience Survey; Swartz et al., 1999), the experience of a positive mental health outcome did not significantly modify their attitudes regarding OPC. However, among those who perceived a high degree of coercion under OPC, a poor mental health outcome was associated with a very low endorsement of benefit of OPC (16.7%), and a positive outcome was associated with a significantly higher prevalence of endorsement of personal benefit of OPC (53%). Previous analyses of coercion by Lidz and colleagues (Lidz et al., 1995) found that the perception of coercion in mental hospital admission was attenuated to the extent that the individual felt he or she was treated fairly or afforded respect, which they termed *procedural justice.* In the current analyses, we are not able to assess the extent of procedural justice afforded subjects nor its effects on coercion.

In previous published analyses from this study, evidence was presented that suggested that the positive effect of OPC in reducing rehospitalizations was particularly strong among individuals with psychotic disorder rather than mood disorder (Swartz et al., 1999). Accordingly, we tested whether subjects in these major diagnostic categories might also differ in the extent to which positive outcomes under OPC would translate into a higher endorsement of the benefit of OPC. Figure 6 displays the results of a stratified analysis by major diagnosis. The association between outcome and OPC endorsement at 12 months was positive and significant in the group with schizophrenia and related diagnoses (psychotic disorders), but it was not significant among patients with bipolar and major depressive diagnoses (mood disorders).

We used logistic regression analysis to test the net impact of a positive mental health outcome on endorsement of personal benefits of OPC at 12 months,

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

Table 1
Endorsement of Outpatient Commitment (OPC) by Sample Characteristics (OPC Sample N = 123)

Variable and characteristic	*N*	% accepting OPC
OPC implementation and outcomes		
Duration of outpatient commitment (OPC)		
1–179 days	69	23.19
180–365 days	54	33.33
Perceived coercion under OPC		
Below median	47	34.04
Above median	75	24.00
Mental health outcomes during study year[a]		
Negative	85	20.00***
Positive	38	44.74
Baseline demographic and clinical characteristics		
Age		
18–39	51	35.29
40 or older	72	22.22
Gender		
Female	55	40.00***
Male	68	17.65
Race		
African American	81	29.63
White/other	42	23.81
Education		
Less than high school	46	26.09
High school grad	67	28.36
More than high school	10	30
Annual income		
$0–$6000	61	26.23
More than $6000	62	29.03
Marital status		
Married	24	37.50
Single/cohabiting	99	25.25
Recent homelessness		
No	99	29.29
Yes	24	20.83
Diagnosis		
Mood disorder	34	20.59
Psychoses	89	30.34
Global Assessment of Functioning (GAF)		
Below median	99	29.29
Above median	24	20.83
Brief Symptom Inventory (BSI)		
Below median	65	24.62
Above median	58	31.03
Substance abuse problems		
No	70	30.00
Yes	53	24.53
Psychiatric admissions in previous year		
0–1	71	25.35
2 or more	52	30.77

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

Table 1
(continued)

Variable and characteristic	*N*	% accepting OPC
Recent fights/violence		
No	44	27.27
Yes	79	27.85
History of medication noncompliance		
No	22	27.27
Yes	101	27.72

[a]Negative outcome = GAF score below median, any hospitalization, or any violent behavior in year; Positive outcome = GAF score above median, no hospitalization, and no violent behavior in year.
***$p < .001$, Fisher's exact two-tailed test.

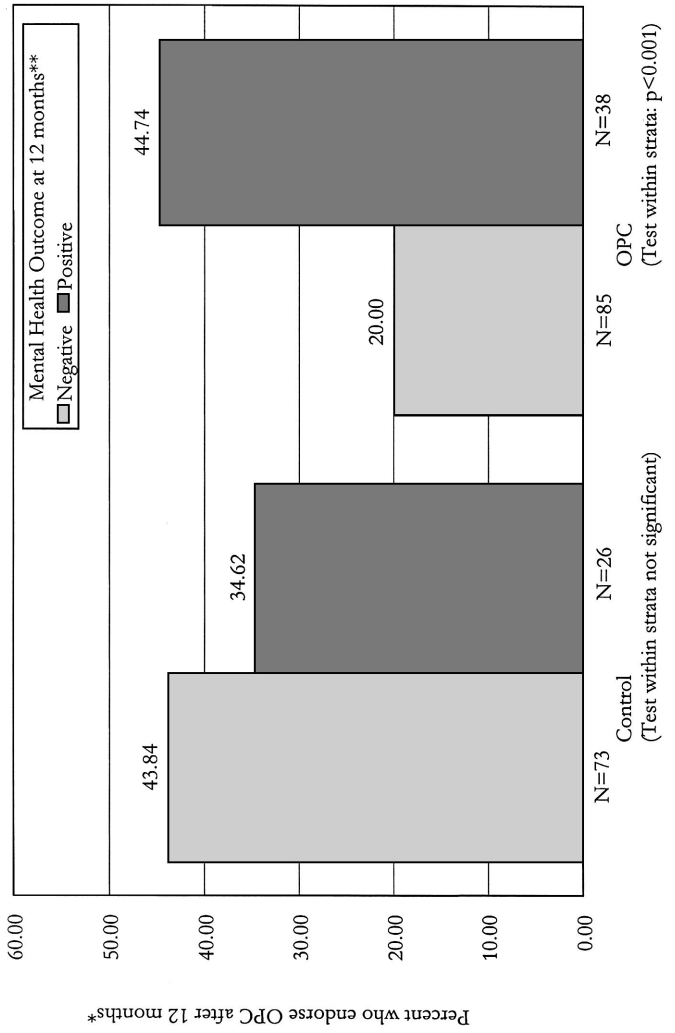
This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

controlling for salient aspects of OPC implementation (i.e., duration of OPC, outpatient service intensity, perceived coercion under OPC) and a series of baseline control variables. Control variables included baseline attitude toward OPC and treatment, demographic factors (age, sex, race, marital status, education, income, and homelessness), and clinical factors (diagnosis, functional impairment, symptom severity, substance abuse problems, violence, and medication compliance). After we adjusted for all of these covariates, the association between positive outcome and endorsement of personal benefits of OPC remained statistically significant (OR = 3.9; $p < .05$; model not shown).

We conducted staged logistic regression analysis with stepwise inclusion to reduce covariates and to test for the interaction of positive outcome with length of exposure to OPC (1 to 179 days vs. 180 to 365 days) in a final model. Previous analyses from this study have shown that duration of OPC is a key factor in its effectiveness in reducing hospitalization, violence, and arrests, as well as in improving treatment compliance (Swanson et al., 2000, 2001; Swartz et al., 1999; Swartz, Swanson, Wagner, Burns, & Hiday, 2001). Table 2 shows that duration of OPC also affects the extent to which such positive outcomes influence subjective perception of personal benefit attributed to OPC.

Specifically, the model shown in Table 2 tests whether the experience of a positive outcome under OPC interacts with the duration of court-ordered treatment (more vs. less than 6 months) to increase the likelihood of an endorsement of the personal benefits of OPC at the end of the study year. This model shows that a positive outcome without extended OPC did not significantly increase the odds of endorsement of benefit. Similarly, extended OPC alone, without a positive outcome as defined, did not significantly increase the odds of endorsement of the personal benefit of OPC. However, subjects who both received extended OPC and experienced a positive mental health outcome were significantly more likely to endorse the personal benefits of OPC, that is, to subscribe to the belief that OPC helps improve treatment adherence while also acknowledging their continuing need for treatment (OR = 3.91; $p < .01$).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

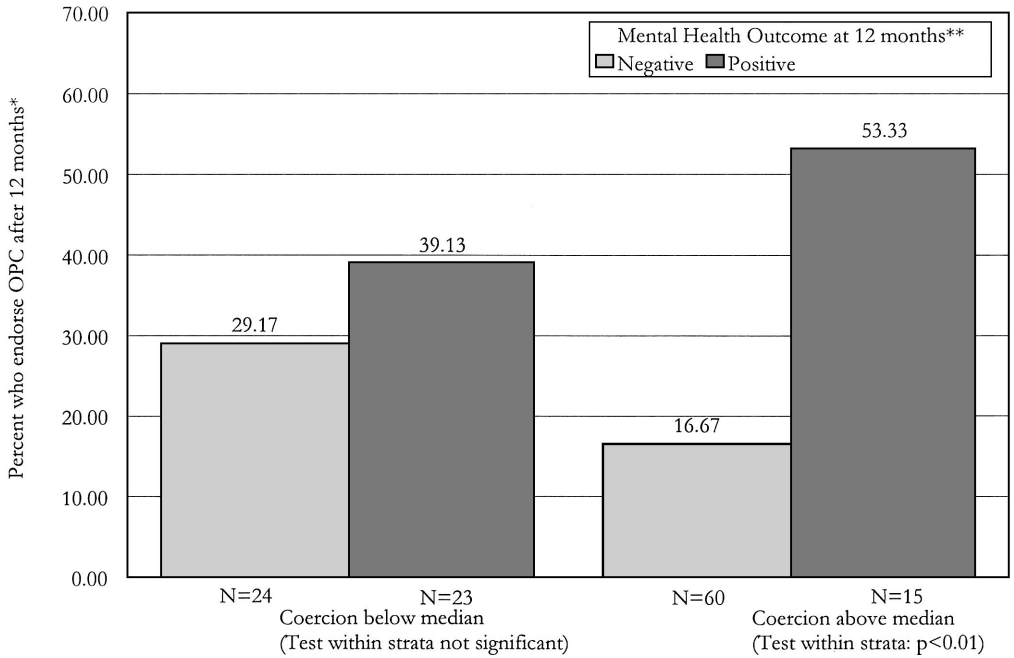


*OPC endorsement: Subject (1) acknowledges continuing need for treatment; and (2) endorses OPC as helpful in keeping appointments and/or staying on prescribed medications

**Outcome: Positive=12 month GAF above median, no hospitalization, no violence
Negative=12 month GAF below median, hospitalization, and/or violence

Figure 4. Personal attitude toward involuntary outpatient commitment (OPC) by experimental group and mental health outcomes at 12 months. GAF = Global Assessment of Functioning.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

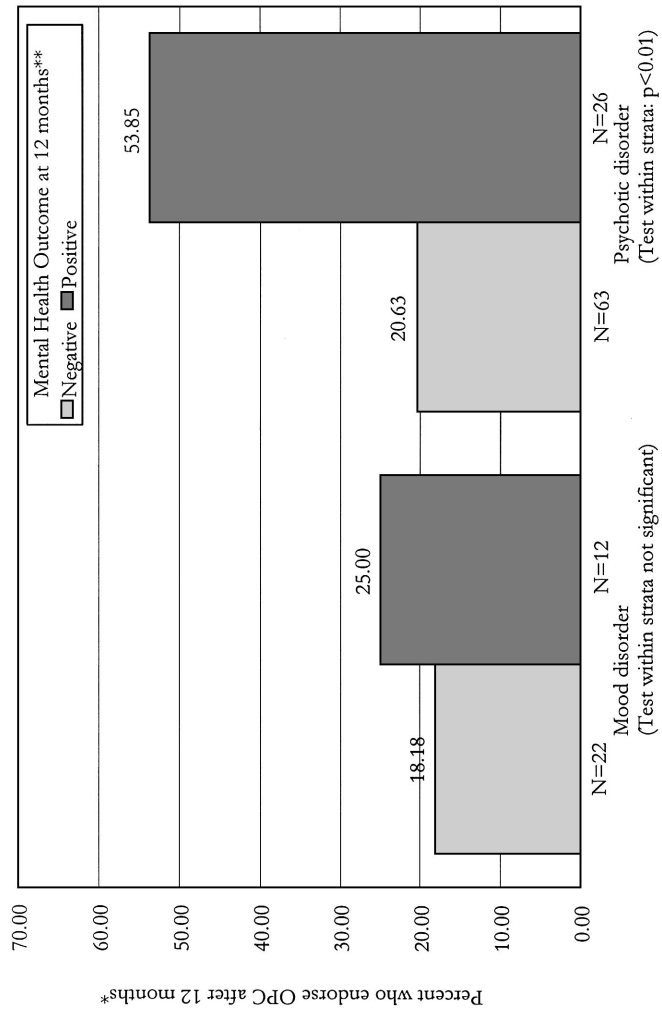


*OPC endorsement: Subject (1) acknowledges continuing need for treatment; and (2) endorses OPC as helpful in keeping appointments and/or staying on prescribed medications

**Outcome: Positive=12 month GAF above median, no hospitalization, no violence
Negative=12 month GAF below median, hospitalization, and/or violence

Figure 5. Personal attitude toward involuntary outpatient commitment (OPC) by degree of perceived coercion and outcomes at 12 months. GAF = Global Assessment of Functioning.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.



*OPC endorsement: Subject (1) acknowledges continuing need for treatment; and (2) endorses OPC as helpful in keeping appointments and/or staying on prescribed medications

**Outcome: Positive=12 month GAF above median, no hospitalization, no violence
Negative=12 month GAF below median, hospitalization, and/or violence

Figure 6. Personal attitudes toward involuntary outpatient commitment (OPC) by diagnostic category and outcomes at 12 months. GAF = Global Assessment of Functioning.

Table 2
Predictors of Endorsement of Outpatient Commitment (OPC) at 12 Months

Variable	Odds ratio	95% confidence interval
Baseline endorsement of OPC	1.45	(0.55–3.82)
OPC implementation and outcomes interaction		
Perceived coercion under OPC	0.94	(0.84–1.06)
Brief OPC/bad outcome [comparison group]	[1.00]	
Extended OPC/bad outcome	1.87	(0.56–6.17)
Brief OPC/good outcome	2.81	(0.70–11.24)
Extended OPC/good outcome	3.91*	(1.07–14.36)
Baseline predictors selected at $p < .10$		
Male vs. female	0.26**	(0.10–0.67)
Psychotic vs. mood disorder	2.85†	(0.96–8.40)
Baseline predictors tested but not selected by model		
Age		
Race		
Marital status		
Education		
Income		
Social support		
Homelessness		
Global Assessment of Functioning		
Brief Symptom Inventory (BSI) score		
Substance abuse problems		
Previous year hospital admissions		
Recent fights/violence		
History of medication noncompliance		

Model statistics: Likelihood ratio chi-square with 7 $df = 21.67$, $p = .0029$. Proportion of variance explained by model: Somers' D = 0.497. Rank correlation of predicted to observed probabilities: C = 0.749.
†$p < .10$. *$p < .05$. **$p < .01$.

Discussion

We find that the majority of experimental subjects who underwent a period of OPC did not personally endorse OPC's benefits at the end of the trial, either because they did not think it improved treatment adherence or because they rejected their need for continued treatment. Indeed, only 27.6% of subjects endorsed the personal benefits of OPC at the end of the trial or study. However, at the end of the study, a positive appraisal of benefit was roughly twice as likely among subjects with positive treatment outcomes compared to those with less than positive treatment outcomes (44.7% vs. 20.0%). Moreover, a change from a negative to a positive view of the personal benefits of OPC (i.e., a positive reappraisal) was much more likely among subjects who experienced a positive mental health outcome under OPC than those who did not (18.4% vs. 7.4%). The experience of coercion during the study, which in previous studies was found to be positively associated with OPC and especially with extended OPC (Swartz et al., 1999), also had a substantial bearing on the appraisal of personal benefit. Subjects who experienced high levels of coercion were unlikely to endorse OPC benefit unless they experienced positive treatment outcomes.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

We have reported elsewhere that extended OPC (clinicians maintain a sustained and consistent treatment approach combined with frequent services) is associated with a range of positive outcomes, albeit at the expense of increased experience of coercion (Swartz et al., 1999; Swartz, Swanson, Hiday, et al., 2001). In the multivariate analyses reported here, we find that subjects who received this sustained exposure to OPC (an exposure that we argue represents its fullest implementation) and who experienced positive outcomes were nearly four times as likely to endorse OPC's personal benefits. Male subjects, independent of treatment outcomes, were nearly four times less likely than females to ascribe personal benefit to OPC, perhaps because they found OPC to be a larger infringement on autonomy. We have previously reported this gender effect (Swartz et al., 1999).

Taken together, these findings suggest that good treatment outcomes do make a difference in the positive personal appraisal of OPC. However, the modest rates of endorsement of OPC benefits overall suggest that, for most people, OPC remains unwanted either because it is seen as ineffective or because future treatment is felt to be unnecessary. As a result, we find little basis to support Stone's thank-you theory; most subjects view OPC at least ambivalently and with little gratitude.

Should we have expected higher rates of endorsement of personal benefit of OPC? Perhaps not. Our composite measure of OPC endorsement hinges on a perceived need for future treatment, which is assessed by utilizing items extracted from a longer measure of insight into illness (McEvoy et al., 1989). In some studies, insight or awareness of illness is relatively independent of state of recovery; many persons with severe mental illness do not acknowledge their need for treatment even after their acute stage of illness abates in response to treatment (Jorgensen, 1995; Smith, Hull, & Santos, 1998). An expectation for change in perceived need for treatment after a period of sustained court-ordered treatment may be an unrealistic measure of benefit of OPC. Recovery of insight may not be expected in persons with a progressive downhill course of illness. Similarly, a retrospective "thank you" may also be unrealistic in persons with such an illness trajectory. If recovery of insight is least likely to occur among more impaired individuals, these may be the very individuals most in need of, yet least likely to endorse, the benefits of mandated treatment.

One might even advance an argument that any statements endorsing the personal benefits of mandatory treatment are suspect when they come from persons who have been recently coerced or from persons about to be coerced. Such statements are merely manifestations of the coercion that is inherent in forced treatment. In other words, acceptance of outpatient commitment under the threat of or after being exposed to forced treatment may reflect a form of acquiescence on the part of disempowered individuals who have come to identify with the agents of their control (psychiatrists, the courts).

Our findings also raise certain philosophical questions regarding what it means to show concern and respect for persons with severe mental illness and how to best understand such persons as moral agents. These questions suggest the need for a broader conception of the person than is generally deployed in arguments about mental health law or about the desirability of OPC based on evidence of retrospective acknowledgment of benefit by those subjected to invol-

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

untary treatment. In fact, this conception of the person raises difficulty for any thank-you justification, whether in mental health law or in related areas. The standard thank-you theory implicitly assumes that one shows respect for a person by respecting the requests, attitudes, or desires of the person after the episode of involuntary treatment. Thus, the question of why the attitudinal state after the fact should be given deference over the attitudes of prior or later state arises as a normative matter. One reason, for example, to give greatest weight to the views of the subjects at the end of the study is that they have recently experienced outpatient commitment (in some cases, for the first time) and thus may be able to give a more informed opinion. It is ironic, however, that the recent experience of outpatient commitment may result in a less accurate and enduring opinion if the patient is distraught or angry and may outweigh other relevant or more enduring considerations. Thus, the views of the subjects at the beginning of the study may be more enduring or more reflective of the subjects' "true" preferences, if their views immediately after receiving OPC are heavily influenced by their recent experiences.

Another interesting question arises if two equally informed and capable appraisals of OPC by the same subject present significantly different attitudes about the benefits and detriments of outpatient commitment at different points in time. One would then need to ask which set of appraisals can best be seen as underlying the "truest" preferences of the subject and which are most representative of the whole person and, therefore, are most worthy of respect. Perhaps we could find the best reconstruction of the person's preferences by asking which reconstruction best manifests the preferences of the whole person over time.

Indeed, many persons with severe mental illness may harbor sharply ambivalent attitudes about treatment; they desire relief from suffering, while rejecting a view of themselves as chronically mentally ill and in need of continuing psychiatric intervention. Thus, they may accept treatment one day and reject it the next. One ethical argument for outpatient commitment, it would seem, is that a person's wish for relief through continuing treatment may be attributed to that person over time and should be respected and supported by appropriate means, even though the expression of that wish for relief is variable, ambivalent, and even opaque due to particular cognitive symptoms of their illness.

These findings suggest that imposition of OPC may be inherently unwelcome, with the following exception: In patients who have experienced sustained OPC and objectively positive treatment outcomes, future OPC may be less a source of resistance. It must also be acknowledged that these subjects may well be relatively uncommon. These results also have implications for decision making about continuing OPC in a number of areas. For clinicians seeking acceptance and gratitude ex post facto as a justification for prolonged OPC, a so-called "thank-you" justification, little support for such a rationale can be found in these data. Rather, decision makers must decide about extending OPC largely in the face of lack of endorsement of OPC by clients. Hence, these clinicians will need to rely on other clinical and empirical data to support decision making about OPC continuation.

Several limitations to these findings should be acknowledged. Because several of our 12-month measures were assessed cross-sectionally, the causal ordering of our results should be interpreted cautiously. For example, it is possible that

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

individuals experienced good treatment outcomes in part because they acknowledged the need for treatment during the course of the experiment and thus were more adherent and achieved an objectively better response to treatment. Moreover, a subject's initially positive appraisal of OPC's benefits could reflect a stronger alliance with a treatment provider, which could, in turn, contribute to good outcomes and to a continuing reinforcement of the idea that OPC provides a personal benefit.

However, it is worth remembering that all of these subjects had been involuntarily hospitalized at baseline, and all had met the legal criteria for OPC. On the face of it, then, all of the subjects had some significant history of poor adherence and poor outcomes in community-based treatment. In each case, a qualified psychiatrist and the court had made a judgment that the subject had a persistent illness that impaired his or her ability to comply voluntarily with recommended continued treatment in the community; without such continued treatment, it was predicted that the subject would deteriorate clinically to the point of dangerous behavior or grave disablement. Thus, it is almost counterintuitive to expect that most people in a group defined by these criteria will experience a meaningful recovery of insight as a consequence of court-ordered treatment, that is to say, recovery of insight manifest as an autonomous retrospective endorsement of a personal benefit attributable to having been coerced into treatment.

Our study design deviates in several ways from a strict randomized controlled trial. Salient to this study, we were not able to experimentally control the duration of OPC. Rather than being subject to experimental manipulation, OPC duration varied as clinicians and judges applied the legal criteria for renewal of OPC orders. This could have led to a biased conclusion about the effects of extended OPC in multivariate models. However, this should only be a problem if subjects who were more likely to comply and improve with treatment were also selectively more likely to get renewal of their court order. In fact, respondents who had been least compliant with medications in the 4 months prior to study entry were significantly more likely to receive extended OPC after their initial court order expired (Swanson et al., 2000). If bias existed in the selection of subjects for longer periods of OPC, such a bias would seem to work against finding that extended OPC and improved treatment outcomes are associated with a positive appraisal of the personal benefits of OPC.

Conclusion

These analyses shed light on an important dimension of court-ordered treatment—the appraisal of its benefits from the perspective of individuals who experienced it. From the measures available to assess this appraisal of OPC's benefits, we found that these benefits were only endorsed by a minority of subjects. A next step in evaluating the social costs and benefits of OPC is to ask the following question: Would subjects be willing to trade-off the lost autonomy under OPC for its potential benefits? Results from a new study that poses that question are forthcoming.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

References

Adams, N. H. S., & Hafner, R. J. (1991). Attitudes of psychiatric patients and their relatives to involuntary treatment. *Australian and New Zealand Journal of Psychiatry, 25,* 231–237.

Allen, M., & Smith, V. F. (2001). Opening Pandora's box: The practical and legal dangers of involuntary outpatient commitment. *Psychiatric Services, 52,* 342–346.

Appelbaum, P. S. (2001). Thinking carefully about outpatient commitment. *Psychiatric Services, 52,* 347–350.

Borum, R., Swartz, M., Riley, S., Swanson, J., Hiday, V., & Wagner, R. (1999). Consumer perceptions of involuntary outpatient commitment. *Psychiatric Services, 50,* 1489–1491.

Campbell, J., & Shraiber, R. (1989). *In pursuit of wellness: The well-being project.* Sacramento, CA: California Department of Mental Health.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: A brief report. *Psychological Medicine, 13,* 595–605.

Edelsohn, G. A., & Hiday, V. A. (1990). Civil commitment: A range of patient attitudes. *Bulletin of the American Academy of Psychiatry and the Law, 18,* 65–77.

Endicott, J., Spitzer, R., Fleiss, J., & Cohen, J. (1976). The global assessment scale: A procedure for measuring overall severity of psychiatric disturbances. *Archives of General Psychiatry, 33,* 766–771.

Fernandez, G. A., & Nygard, S. (1990). Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina. *Hospital and Community Psychiatry, 41,* 1001–1004.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). *Structured Clinical Interview for Axis I and II DSM-IV disorders-patient edition (SCID-I/P).* Washington, DC: APA Press.

Gardner, W., Lidz, C. W., Hoge, S. K., Monahan, J., Eisenberg, M. M., Bennett, N. S., et al. (1999). Patients' revisions of their beliefs about the need for hospitalization. *The American Journal of Psychiatry, 156,* 1385–1391.

George, L., Blazer, D., & Hughes, D. (1989). Social support and the outcomes of major depression. *British Journal of Psychiatry, 182,* 651–656.

Gerbasi, J. B., Bonnie, R. J., & Binder, R. L. (2000). Resource document on mandatory outpatient treatment. *Journal of the American Academy of Psychiatry and the Law, 28,* 145–148.

Hiday, V. A. (1992). Coercion in civil commitment: Process, preferences, and outcome. *International Journal of Law and Psychiatry, 15,* 359–377.

Hiday, V. A., & Scheid-Cook, T. L. (1987). The North Carolina experience with outpatient commitment: A critical appraisal. *International Journal of Law and Psychiatry, 10,* 215–232.

Hiday, V. A., & Scheid-Cook, T. L. (1989). A follow-up of chronic patients committed to outpatient treatment. *Hospital and Community Psychiatry, 40,* 52–59.

Hiday, V. A., & Scheid-Cook, T. L. (1991). Outpatient commitment for "revolving door" patients: Compliance and treatment. *Journal of Nervous and Mental Disease, 179,* 83–88.

Jorgensen, P. (1995). Recovery and insight in schizophrenia. *Acta Psychiatrica Scandanavica, 92,* 436–440.

Kane, J., Quitkin, F., Rifkin, A., Wegner, J., Rosenberg, G., & Borenstein, M. (1983). Attitudinal changes of involuntarily committed patients following treatment. *Archives of General Psychiatry, 40,* 374–377.

Keilitz, I. (1990). Empirical studies of involuntary outpatient civil commitment: Is it working? *Mental and Physical Disability Law Reporter, 14,* 368–379.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

Kress, K. (2000). An argument for assisted outpatient treatment for persons with serious mental illness illustrated with reference to a proposed statute for Iowa. *Iowa Law Review, 85,* 1269–1386.

Lamb, H. R., & Weinberger, L. E. (2000). A major advance in the laws pertaining to community treatment for persons with severe mental illness. *Journal of the American Academy of Psychiatry and the Law, 28,* 127–144.

Lidz, C. W., Hoge, S. K., Gardner, W., Bennett, N. S., Monahan, J., Mulvey, E. P., & Roth, L. H. (1995). Perceived coercion in mental hospital admission; pressures and process. *Archives of General Psychiatry, 52,* 1034–1039.

Lucksted, A., & Coursey, R. D. (1995). Consumer perceptions of pressure and force in psychiatric treatments. *Psychiatric Services, 46,* 146–152.

Mattison, E. (2000). The law of unintended consequences. *Journal of the American Academy of Psychiatry and the Law, 28,* 127–144.

McEvoy, J., Apperson, L., Appelbaum, P., Ortlip, P., Brecosky, J., Hammill, K., et al. (1989). Insight into schizophrenia: Its relationship to acute psychopathology. *Journal of Nervous and Mental Disease, 177,* 43–47.

Moloy, A. (1992). *Analysis: Critiquing the empirical evidence: Does involuntary outpatient commitment work?* Washington, DC: Mental Health Policy Resource Center.

Mulvey, E. P., Geller, J. L., & Roth, L. H. (1987). The promise and peril of involuntary outpatient commitment. *American Psychologist, 42,* 571–584.

Schwartz, H. I., Vingiano, W., & Perez, C. B. (1988). Autonomy and the right to refuse treatment: Patients' attitudes after involuntary medication. *Hospital and Community Psychiatry, 39,* 1049–1054.

Schwartz, S. J., & Costanzo, C. E. (1987). Compelling treatment in the community: Distorted doctrines and violated values. *Loyola of Los Angeles Law Review, 20,* 1329–1429.

Smith, T. E., Hull, J. W., & Santos, L. (1998). The relationship between symptoms and insight in schizophrenia: A longitudinal perspective. *Schizophrenia Research, 33,* 63–67.

Steadman, H. J., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., & Robbins, P. C. (2001). Assessing the New York City outpatient commitment pilot program. *Psychiatric Services, 52,* 330–336.

Stefan, S. (1987). Preventive commitment: The concept and its pitfalls. *Mental and Physical Disability Law Reporter, 11,* 288–302.

Stein, L. I., & Diamond, R. J. (2000). Commentary: A "systems"-based alternative to mandatory outpatient treatment. *Journal of the American Academy of Psychiatry and the Law, 28,* 159–164.

Stone, A. A. (1975). *Mental health and law: A system in transition.* Rockville, MD: NIMH Center for Studies of Crime and Delinquency.

Swanson, J., Borum, R., Swartz, M., & Hiday, V. (1999). Violent behavior preceding hospitalization among persons with severe mental illness. *Law and Human Behavior, 23,* 185–204.

Swanson, J. W., Borum, R., Swartz, M. S., Wagner, H. R., Burns, B. J., & Hiday, V. A. (2001). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? *Criminal Justice & Behavior, 28,* 156–189.

Swanson, J. W., Swartz, M. S., Borum, R., Hiday, V. A., Wagner, H. R., & Burns, B. J. (2000). Involuntary outpatient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry, 176,* 324–331.

Swanson, J. W., Swartz, M. S., George, L. K., Burns, B. J., Hiday, V. A., Borum, R., & Wagner, H. R. (1997). Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. *Journal of the American Academy of Psychiatry and Law, 25,* 5–16.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.

Swartz, M. S., Burns, B. J., Hiday, V. A., George, L. K., Swanson, J., & Wagner, H. R. (1995). New directions in research on involuntary outpatient commitment. *Psychiatric Services, 46,* 381–385.

Swartz, M. S., Hiday, V. A., Wagner, H., Swanson, J. W., Borum, R., & Burns, B. J. (1999). Measuring coercion under involuntary outpatient commitment: Initial findings from a randomized controlled trial. In J. Morrissey & J. Monahan (Eds.), *Research in community mental health: Vol. 10. Coercion in mental health services* (pp. 57–77). Stamford, CT: JAI Press.

Swartz, M. S., & Monahan, J. (2001). Special section on involuntary outpatient commitment: Introduction. *Psychiatric Services, 52,* 323–324.

Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagner, H. R., & Burns, B. J. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry, 155,* 226–231.

Swartz, M. S., Swanson, J. W., Hiday, V. A., Wagner, H. R., Burns, B. J., & Borum, R. (2001). A randomized controlled trial of outpatient commitment in North Carolina. *Psychiatric Services, 52,* 325–329.

Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J., & Hiday, V. A. (2001). Effects of involuntary outpatient commitment and depot antipsychotics on treatment adherence in persons with severe mental illness. *The Journal of Nervous and Mental Disease, 189,* 583–592.

Torrey, E. F., & Zdanowicz, M. (2001). Outpatient commitment: What, why and for whom? *Psychiatric Services, 52,* 337–341.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.
All rights, including for text and data mining, AI training, and similar technologies, are reserved.